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When Cruel Become the Usual: The Mistreatment of Mentally Ill Inmates in South Carolina Prisons

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WHEN CRUEL BECOMES THE USUAL: THE MISTREATMENT OF MENTALLY ILL INMATES IN SOUTH CAROLINA PRISONS

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I. INTRODUCTION

On February 7, 2008, South Carolina Department of Corrections (SCDC) staff members transferred Jerome Laudman, a schizophrenic, intellectually disabled inmate with a speech impediment, into a cell in "Lee Supermax," a Special Management Unit (SMU) within Lee Correctional Institution.[1] During the transfer, correctional staff sprayed Laudman with chemical munitions, physically abused him, and then left him naked on the floor of a cold, empty isolation cell.[2] On or around February 11, 2008, Laudman stopped eating and taking his medication, but SCDC staff members failed to report his weakening condition.[3] Seven days later, nurses found Laudman on his cell floor, surrounded by feces, vomit, and trays of rotting food.[4] Neither SCDC nurses nor correctional officers would assist Laudman in the cell, waiting instead for two inmates to retrieve Laudman's unconscious body.[5] Laudman died of a heart attack in a local hospital emergency room that afternoon.[6] A SCDC investigator later discovered evidence of an attempted cover-up by correctional officers who tried to clean Laudman's cell before photographs were taken.[7] Although staff had videotaped Laudman's transfer to the SMU cell, as required by SCDC policy, investigators found the tape to be, inexplicably, almost completely blank.[8] SCDC conducted no quality improvement reviews of Lee Supermax procedures and practices after Laudman's death.[9]

On March 8, 2008, after Baxter Vinson—an inmate diagnosed with Borderline Personality Disorder—cut open his own abdomen, he spent over three hours in his cell before correctional staff finally tended to him.[10] Correctional staff responded by confining Vinson to a restraint chair and

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1. T.R. v. S.C. Dep't. of Corr., No.: 2005-CP-40-2925, slip op. at 15 (S.C. Ct. Com. Pl. Jan. 8, 2014).
2. *Id.*
3. *Id.*
4. *Id.*
5. *Id.*
6. *Id.*
7. *Id.*
8. *Id.*
9. *Id.* at 16.
10. *Id.* at 19.

tightening his restraints around his abdominal wound.[11] Vinson remained in this position with his intestines protruding from his abdomen for nearly two hours before receiving medical care.[12]

On February 2, 2010, the Crisis Intervention (CI) cell-check log for inmate Edward Broxton, a record SCDC policy requires to be updated every fifteen minutes for inmates at risk for suicide, noted that he was eating breakfast in his cell at 6:30 a.m.[13] when Broxton had actually hanged himself inside his cell an hour earlier.[14]

These horrific incidents are drawn from hundreds of complaints of neglect, abuse, and violence presented in *T.R. v. South Carolina Department of Corrections*.[15] Brought nearly ten years ago on behalf of a class of approximately 3,500 state inmates who have been classified as seriously mentally ill,[16] the litigation revealed that inmates had died in SCDC facilities due to a "lack of basic mental health care, and hundreds more remain[ed] substantially at risk for serious physical injury, mental decompensation, and profound, permanent mental illness."[17] Ruling for the plaintiff-inmates in January 2014, Judge Michael Baxley somberly observed that "[t]his case, far above all others, [was] the most troubling" he had encountered out of the nearly 70,000 cases filed in his court during his fourteen years as a general jurisdiction judge.[18]

Judge Baxley determined that the evidence submitted by the plaintiff-inmates satisfied the deliberate indifference standard used to assess alleged violations of the South Carolina Constitution's prohibition of cruel and unusual punishment.[19] Accordingly, Judge Baxley ordered SCDC to implement a remedial plan to address the constitutional deficiencies of its mental health system.[20] Although the SCDC had appealed all pretrial, trial, and post-trial bench rulings,[21] in January 2015, the parties reached a preliminary agreement to

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11. *Id.*
12. *Id.*
13. *Id.* at 30.
14. *Id.*
15. No.: 2005-CP-40-2925 (S.C. Ct. Com. Pl. Jan. 8, 2014).
16. *Id.*, slip op. at 1. "For purposes of this suit, the term 'serious mental illness' was specifically defined in the Class Certification order . . . as all SCDC inmates from the date of the filing of the complaint who have been hospitalized for psychiatric services, referred to an Intermediate Mental Health Care Services Unit, or diagnosed by a psychiatrist with . . . Schizophrenia, Schizoaffective Disorder, Cognitive Disorder, Paranoia, Major Depression, Bipolar Disorder, Psychotic Disorder, or any other mental condition that results in significant functional impairment including inability to perform activities of daily living, extreme impairment of coping skills, or behaviors that are bizarre and/or dangerous to self or others." *Id.* at 1–2.
17. *Id.* at 2.
18. *Id.* at 1.
19. *Id.* at 3, 5, 7 (citing S.C. CONST. art. I, § 15).
20. *Id.* at 37–38.
21. Notice of Appeal at 1, T.R. v. S.C. Dep't. of Corr., No.: 2005-CP-40-2925 (S.C. Ct. App. May 16, 2014).

address the numerous constitutional deficiencies found by the court. That agreement now awaits legislative approval and appropriation of the funds necessary for its implementation.[22]

The deficiencies in SCDC's mental health program are egregious, but they are not unusual. Prisons and jails across the country are struggling—and too often failing—to provide adequate treatment to seriously mentally ill inmates.[23] As Judge Baxley cautioned, this situation does not only affect mentally ill inmates and correctional administrators:

> This litigation does not occur in a vacuum. What happens at the Department of Corrections impacts all of us, whether it is from the discharge of untreated seriously mentally ill individuals from prison into the general population, or tremendously increased costs for treatment and care that might have been prevented, or the needless increase in human suffering when use of force replaces medical care. The decisions of our [c]ourts reflect the values of our society. To that end, our state can no longer tolerate a mental health system at [SCDC] that has broken down due to lack of finances and focus.[24]

The mental health care in South Carolina prisons has unquestionably been constitutionally and morally inadequate. If funded and implemented, the parties' preliminary agreement holds the promise of bringing the SCDC system closer to constitutional compliance. However, as the experience of inmates and corrections administrators across the United States reveals, a broader reform agenda is needed. This Note argues that South Carolina's mistreatment of mentally ill prisoners demonstrates that a more comprehensive reform agenda is needed, an agenda that addresses mental illness outside as well as inside prison walls. By focusing on methods that decrease the number of mentally ill persons within the correctional system, South Carolina can address a larger crisis—the criminalization of mental illness.[25]

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22. *See* Meg Kinnard, *S.C. Prisons, Advocates Reach Deal on Inmate Mental Health*, WASH. TIMES (Jan. 15, 2015), http://www.washingtontimes.com/news/2015/jan/15/sc-prisons-advocates-reach-deal-on-inmate-mental-h/; Cynthia Roldan, *Prisons, Advocacy Group Reach Agreement in Mental Health Lawsuit*, POST & COURIER (Jan. 15, 2015, 5:47 PM), http://www.postandcourier.com/article/20150115/PC1603/150119595.

23. *See generally* E. FULLER TORREY ET AL., TREATMENT ADVOCACY CTR. & NAT'L SHERIFFS' ASS'N, THE TREATMENT OF PERSONS WITH MENTAL ILLNESS IN PRISONS AND JAILS: A STATE SURVEY (2014), *available at* http://www.tacreports.org/storage/documents/treatment-behind-bars/treatment-behind-bars.pdf (conducting a fifty-state survey of procedures and deficiencies in U.S. prisons).

24. *T.R.*, slip op. at 3.

25. *See* Timothy Williams, *Jails Have Become Warehouses for the Poor, Ill, and Addicted, a Report Says*, N.Y. TIMES, Feb. 11, 2015, at A19; *see also* RAM SUBRAMANIAN ET AL., VERA INST. OF JUSTICE, INCARCERATION'S FRONT DOOR: THE MISUSE OF JAILS IN AMERICA 11 (2015), *available at* http://www.vera.org/sites/default/files/resources/downloads/incarcerations-front-door-report.pdf (discussing research that reveals the mass incarceration of poor, mentally ill, and

Part II.A of this Note begins with a brief history of how the deinstitutionalization of America's mentally ill tragically turned too frequently into "transinstitutionalization"[26] as they were confined in prisons and jails after community mental health services never materialized. Part II.B then charts the development of Eighth Amendment protections for mentally ill inmates while Part II.C examines how the federal Prison Litigation Reform Act influenced the plaintiff-inmates' decision to litigate in South Carolina state court. Part III reviews the application of the relevant legal standard to the evidence presented, including the documentation of SCDC's knowledge of the constitutional violations being perpetrated in its facilities. After examining the court's remedial recommendations and the terms of the parties' preliminary agreement, Part IV compares the remedial steps contemplated in South Carolina with those undertaken in other jurisdictions. Part V concludes by exploring how New York City's recently announced initiative to alleviate the mental health care crisis in its jail system may point toward a path South Carolina should follow.

II. HISTORICAL AND LEGAL BACKGROUND

A. The Growing Mentally Ill Population in U.S. Prisons and Jails: The Genesis of a National Crisis

From the mid-1950s through the 1970s, advocates for the mentally ill pushed for patient deinstitutionalization.[27] This campaign, coupled with multiple medical, social, and legal developments, produced dramatic change,[28] specifically the release of thousands of previously confined persons with mental illness.[29]

On the medical front, the introduction of new psychiatric medications gave mental health professionals alternatives to traditional treatments for the

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substance-addicted individuals in the United States). This Note's argument is restricted to SCDC inmates' treatment once inside SCDC custody. It is assumed, for the purposes of this Note, that all inmates specifically discussed were rightly convicted.

26. For a definition of transinstitutionalization in the context of mentally ill individuals, see Ralph Slovenko, *The Transinstitutionalization of the Mentally Ill*, 29 OHIO N.U. L. REV. 641, 641 (2003).

27. *See* CHRIS KOYANAGI, KAISER COMM'N ON MEDICAID & THE UNINSURED, LEARNING FROM HISTORY: DEINSTITUTIONALIZATION OF PEOPLE WITH MENTAL ILLNESS AS PRECURSOR TO LONG-TERM CARE REFORM 1, 4 (2007), *available at* https://kaiserfamily foundation.files.wordpress.com/2013/01/7684.pdf; *cf.* E. FULLER TORREY, NOWHERE TO GO: THE TRAGIC ODYSSEY OF THE HOMELESS MENTALLY ILL 2–4 (1988) (describing the effect deinstitutionalization had on the mentally ill individuals who had been treated in public facilities).

28. *See* Bernard E. Harcourt, *Reducing Mass Incarceration: Lessons from the Deinstitutionalization of Mental Hospitals in the 1960s*, 9 OHIO ST. J. CRIM. L. 53, 65 (2011).

29. The number of mentally ill patients housed in state-run institutions was reduced from 559,000 in 1956 to 154,000 in 1980. KOYANAGI, *supra* note 27, at 4.

symptoms of mental illness.[30] "Prior to the development of psychiatric drug therapy, . . . treatments for mental illness included electroconvulsive therapy, insulin coma therapy, and lobotomy."[31] The use of such treatments rapidly decreased with the introduction of antipsychotic medications such as Thorazine.[32] Medication therapy offered many possibilities, including the opportunity for treatment of symptoms on an outpatient basis.[33]

The implementation of federal programs and economic cost-shifting incentives further spurred deinstitutionalization. The 1961 Joint Commission on Mental Health report, *Action for Mental Health*, called for shifting the delivery of psychiatric services in the United States away from state-run mental hospitals to community-based facilities.[34] In the ten volume report, the Joint Commission assessed mental health conditions and resources, and developed a national plan with the goal of furnishing prevention and early intervention services through greater funding and training devoted to mental health services.[35] President John F. Kennedy, influenced by the Commission's report, proposed the Community Mental Health Centers Act in 1963.[36] Over the next two decades, pursuant to the Act, Congress created federal programs to build community health centers[37] and to fund the staffing of such facilities.[38] In addition, emerging programs such as Medicaid, Medicare, and Supplemental Security Income gave states financial incentives to transition patients away from state mental hospitals into federally subsidized nursing homes and psychiatric wards of general hospitals.[39]

Most dramatically, exposés revealing the harms of institutionalization created momentum for deinstitutionalization initiatives.[40] Sociological studies in

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30. *See* Harcourt, *supra* note 28, at 65–66 (quoting William Gronfein, *Psychotropic Drugs and the Origins of Deinstitutionalization*, 32 SOC. PROBS. 437, 442 (1985)) (citing E. FULLER TORREY, OUT OF THE SHADOWS: CONFRONTING AMERICA'S MENTAL ILLNESS CRISIS 99 (1997); Gronfein, *supra*, at 441–42, 444).

31. *Id.* at 65 (citing Gronfein, *supra* note 30, at 444).

32. *See id.* at 65–66 (quoting Gronfein, *supra* note 30, at 442) (citing TORREY, *supra* note 30, at 99; Gronfein, *supra* note 30, at 441–42).

33. *Id.* at 66.

34. KOYANAGI, *supra* note 27, at 5. The Joint Commission was created by Congress to analyze and evaluate the mental health conditions and resources of the United States and to make recommendations to address the needs of the mentally ill. *See id.*

35. *Id.*

36. Harcourt, *supra* note 28, at 67 (citing BERNARD L. BLOOM, COMMUNITY MENTAL HEALTH: A GENERAL INTRODUCTION 20 (2d ed. 1984)); *see also* KOYANAGI, *supra* note 27, at 5 (noting President Kennedy's recommendations to Congress).

37. KOYANAGI, *supra* note 27, at 5 (citing Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, Pub. L. No. 88-164, § 201, 77 Stat. 282, 290). Despite the Joint Commission and President Kennedy's recommendation that funding for mental health be tripled, "[f]ederal funds for the community mental health centers program did not come close to approaching the early promises or projections of need." *Id.* at 5, 11.

38. *Id.* at 5 (citing Mental Retardation Facilities and Community Mental Health Centers Construction Act Amendments of 1965, Pub. L. No. 89-105, sec. 2(b), § 220, 79 Stat. 427, 428).

39. Harcourt, *supra* note 28, at 67.

40. *See id.* at 68.

the 1950s and 1960s revealed that state mental hospitals were not therapeutic environments, but were instead "vast dehumanizing warehouses whose neglected, ill-fed, and abused inmates could, with little exaggeration, be counted among the living dead."[41] These reports showed that the asylum life had actual anti-therapeutic effects on patients, often exacerbating patients' conditions instead of curing them.[42] Articles in popular publications such as *Reader's Digest* and *Life* magazine documented the inadequate and inhumane treatment to which mental patients were subjected, presenting horrifying narratives and graphic photos of neglect and mistreatment.[43] Books such as Mary Jane Ward's *The Snake Pit*, Sylvia Plath's *The Bell Jar*, and Ken Kesey's *One Flew Over the Cuckoo's Nest* also provided shocking accounts of life in mental institutions.[44] As institutional settings proved to do more harm than good for many patients and drug therapy became an option, shifts to alternative settings received public approval.

Harnessing public outrage at institutional abuses, advocates for the mentally ill set out to "liberate" them by filing legal challenges attacking the constitutionality of procedures governing commitment and treatment.[45] In *O'Connor v. Donaldson*,[46] the Supreme Court reviewed Florida's involuntary commitment protocol and held that a state could not "constitutionally confine without more a non[-]dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends."[47] Other suits successfully attacked deficiencies in treatment. In *Wyatt v. Stickney*,[48] the U.S. District Court for the Middle District of Alabama found that Alabama was unable to meet constitutionally guaranteed minimal standards of care[49] and ordered the release of thousands of patients from state mental hospitals.[50]

The convergence of these three developments produced a substantial reduction of the number of mentally ill patients housed in state public mental

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41. Nancy K. Rhoden, *The Limits of Liberty: Deinstitutionalization, Homelessness, and Libertarian Theory*, 31 EMORY L.J. 375, 380 (1982).

42. *See id.* at 381.

43. Harcourt, *supra* note 28, at 68–69 (quoting JOSEPH HALPERN ET AL., THE MYTHS OF DEINSTITUTIONALIZATION: POLICIES FOR THE MENTALLY DISABLED 3 (1980)) (citing NANA RIDENOUR, MENTAL HEALTH IN THE UNITED STATES: A FIFTY-YEAR HISTORY 106 (1961)).

44. *Id.* at 69.

45. *See* TORREY, *supra* note 27, at 88–89; Harcourt, *supra* note 28, at 70.

46. 422 U.S. 563 (1975).

47. *Id.* at 576; *see also* Addington v. Texas, 441 U.S. 418, 433 (1979) (requiring "clear and convincing" evidence in a civil commitment proceeding that may result in indefinite confinement).

48. 334 F. Supp. 1341 (M.D. Ala. 1971).

49. *Id.* at 1343–44 (holding that the absence of privacy for patients, an overcrowded and hazardous physical environment, and a poorly trained and shorthanded staff constituted a grossly deficient level of treatment). *See generally* Philipp v. Carey, 517 F. Supp. 513, 517 (N.D.N.Y. 1981) (collecting cases defining minimal standards of care for treatment or habilitation).

50. *See* Harcourt, *supra* note 28, at 71 (citing E. FULLER TORREY, OUT OF THE SHADOWS: CONFRONTING AMERICA'S MENTAL ILLNESS CRISIS 144 (1997)).

hospitals from 559,000 in 1956 to 154,000 patients in 1980.[51] Although this decline would seem to signal victory for the deinstitutionalization movement, the result was, in fact, the diversion of many of these patients into nursing homes, adult care facilities, onto the streets, and ultimately often into the correctional system.[52] Critics of deinstitutionalization have labeled this phenomenon, shifting the confinement of the mentally ill from one set of institutions to another, "transinstitutionalization."[53]

From its inception, the deinstitutionalization process exhibited major weaknesses. The new plans for community-based treatment often did not account for critical aspects of care: procuring suitable living situations upon patients' release; arranging for the delivery of essential supportive services such as inpatient, outpatient, emergency, partial hospitalization, and consultation and education on mental health; ensuring sufficient connection and communication between state and federal policies and institutions to ensure continuity of care; developing measures of success for patients; and most importantly, providing adequate funding.[54] Consequently, by 1984 "'more than 50% of nursing homes [were] populated by persons with primary or secondary diagnoses of mental disorder; thousands of disturbed persons wander[ed] [the] urban landscape without housing; and legions inhabit[ed] welfare hotels, board and care homes, and adult residences.'"[55]

With limited community care options for individuals with mental illness, the criminal justice system became the default option when law enforcement officials had to respond to individuals experiencing psychiatric crises.[56] In such situations, "police [we]re 'inclined to charge persons with mental illness with a misdemeanor and take them to jail if they th[ought] no appropriate alternatives [we]re available, a practice referred to as mercy booking.'"[57] Because so-called "lifestyle crimes" such as vagrancy and drug and alcohol use are common among the mentally ill, police could easily justify the incarceration option.[58] Responding officers may have lacked sufficient training to recognize mental

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51. *See* KOYANAGI, *supra* note 27, at 4.

52. *See id.* at 13 (citing RICHARD G. FRANK & SHERRY A. GLIED, BETTER BUT NOT WELL: MENTAL HEALTH POLICY IN THE UNITED STATES SINCE 1950 (2006)).

53. *See, e.g.*, Slovenko, *supra* note 26, at 654 (describing the shift as a move toward "a new custodialism replete with its own failures and shortcomings").

54. KOYANAGI, *supra* note 27, at 11.

55. Slovenko, *supra* note 26, at 654 (quoting John A. Talbott, *Psychiatry's Agenda for the 80s*, 251 JAMA 2250, 2250 (1984)).

56. *See id.* at 655 (quoting H. Richard Lamb et al., *The Police and Mental Health*, 53 PSYCHIATRIC SERVICES 1266, 1267 (2002)).

57. *Id.* (quoting Lamb et al., *supra* note 56, at 1267).

58. *See* Shane Levesque, *Closing the Door: Mental Illness, the Criminal Justice System, and the Need for a Uniform Mental Health Policy*, 34 NOVA L. REV. 711, 719 (2010) (citing MARCIA K. GOIN, AM. PSYCHIATRIC ASS'N, MENTAL ILLNESS AND THE CRIMINAL JUSTICE SYSTEM: REDIRECTING RESOURCES TOWARD TREATMENT, NOT CONTAINMENT 4 (2004), *available at* http://www.floridatac.com/files/document/Mental%20Illness%20and%20the%20CJ%20System%20-%20Redirecting%20Resources%20Toward%20Treatment,%20Not%20Containment.pdf).

illness as the cause of the conduct they encountered and, therefore, never considered more appropriate responses than arrest and incarceration.[59] As a result, thousands of mentally ill individuals now find themselves warehoused in jails and prisons, the new de facto mental health treatment centers in the United States.[60]

A 2013 study provided empirical confirmation that the deinstitutionalization of mentally ill patients has increased American incarceration rates by an estimated 4%–7% between 1980 and 2000.[61] Although this number represents a small contribution to overall prison population growth, the study's authors stress that a large portion of mentally ill inmates would not have been incarcerated if not for deinstitutionalization.[62]

Using statistics from recent U.S. Department of Justice reports, it is estimated that state prisons and local jails housed approximately 356,000 inmates classified as seriously mentally ill in 2012.[63] Comparing this figure to the approximately 35,000 psychiatric beds available in mental hospitals nationwide, there are ten times as many people with serious mental health issues in prisons and jails than there are in mental hospitals.[64] With such a sizeable mentally ill population in the criminal justice system, prison and jail administrators face the challenge of operating a mental hospital within a correctional facility, a mission the correctional system is not designed, staffed, or funded to accomplish.[65] Consequently, prisoners often go without the appropriate treatment and care, and a pattern of abuse and neglect emerges.[66] This pattern requires constitutional redress.

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59. *See id.* (citing GOIN, *supra* note 58, at 3); *see also* Michael S. Woody, *Dutiful Minds: Dealing With Mental Illness*, 32 CAP. U. L. REV. 1051, 1052 (2004) (examining law enforcement's understanding of the need for more adequate training to prevent deliberate indifference to the rights of mentally ill citizens); Megan Pauly, *How Police Officers Are (or Aren't) Trained in Mental Health*, ATLANTIC (Oct. 11, 2013, 9:07 AM), http://www.theatlantic.com/health/archive/2013/10/how-police-officers-are-or-aren-t-trained-in-mental-health/280485/ (discussing the importance of law enforcement training to prevent stigmatization and misunderstanding of mentally ill individuals).

60. *See* Slovenko, *supra* note 26, at 657.

61. Steven Raphael & Michael A. Stoll, *Assessing the Contribution of the Deinstitutionalization of the Mentally Ill to Growth in the U.S. Incarceration Rate*, 42 J. LEGAL STUD. 187, 190 (2013).

62. *Id.*

63. TORREY ET AL., *supra* note 23, at 101 (citing E. ANN CARSON & WILLIAM J. SABOL, U.S. DEP'T OF JUSTICE, PRISONERS IN 2011 (2012), *available at* http://www.bjs.gov/content/pub/pdf/p11.pdf; TODD D. MINTON, JAIL INMATES AT MIDYEAR 2012: STATISTICAL TABLES (2013), *available at* http://www.bjs.gov/content/pub/pdf/jim12st.pdf).

64. *Id.*

65. *See* Nicholas Kristof, Op-Ed., *Inside a Mental Hospital Called Jail*, N.Y. TIMES, Feb. 9, 2014, at SR1.

66. *See, e.g.*, Andrew Cohen, *When Good People Do Nothing: The Appalling Story of South Carolina's Prisons*, ATLANTIC (Jan. 10, 2014, 12:35 PM), http://www.theatlantic.com/national/archive/2014/01/when-good-people-do-nothing-the-appalling-story-of-south-carolinas-

B. Development of Eighth Amendment Protection for Inmates

The Eighth Amendment to the United States Constitution prohibits the infliction of cruel and unusual punishment.[67] Originally applied to constrain the manner and forms of punishment,[68] the Amendment, as explained by the Supreme Court in *Estelle v. Gamble*,[69] also establishes the "'broad and idealistic concepts of dignity, civilized standards, humanity, and decency' against which [the Court] must evaluate penal measures,"[70] including the conditions of confinement and the provision of adequate health care. Noting that its Eighth Amendment precedents had consistently repudiated "punishments which are incompatible with 'the evolving standards of decency that mark the progress of a maturing society' or which 'involve the unnecessary and wanton infliction of pain,'"[71] the *Estelle* Court rooted a governmental obligation to provide medical care to inmates on the common law principle "that 'it is but just that the public be required to care for the prisoner, who cannot by reason of the deprivation of his liberty, care for himself.'"[72] The Court concluded that deliberate indifference to prisoners' serious medical needs "constitute[d] the 'unnecessary and wanton infliction of pain' proscribed by the Eighth Amendment."[73]

To prove an Eighth Amendment violation under *Estelle*, inmates must show that correctional officials have exhibited deliberate indifference to inmates' serious medical needs.[74] This standard has both objective and subjective components.[75] As explained in *Wilson v. Seiter*,[76] an Eighth Amendment claim must satisfy an objective standard by presenting evidence of a deprivation that is "sufficiently grave" so as to constitute "denying 'the minimal civilized measure of life's necessities.'"[77] The *Wilson* Court underscored that inmates cannot succeed by simply citing the "overall conditions" of the prison but must instead

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prisons/282938/?single_page=true (describing how the government and the public ignored signs of mentally ill prisoners' mistreatment).

67. U.S. CONST. amend. VIII.

68. *See* Atkins v. Virginia, 536 U.S. 304, 311 (2002); Solem v. Helm, 463 U.S. 277, 284 (1983); Weems v. United States, 217 U.S. 349, 367 (1910). *See generally* Gregg v. Georgia, 428 U.S. 153, 169–73 & nn.17–18 (1976) (joint opinion of Stewart, Powell & Stevens, JJ.) (citations omitted) (providing a historical account of the Court's application of the Eighth Amendment).

69. 429 U.S. 97 (1976).

70. *Id.* at 102 (quoting Jackson v. Bishop, 404 F.2d 571, 579 (8th Cir. 1968)).

71. *Id.* at 102–03 (quoting *Gregg*, 428 U.S. at 173 (joint opinion of Stewart, Powell & Stevens, JJ.); Trop v. Dulles, 356 U.S. 86, 101 (1958) (plurality opinion)).

72. *Id.* at 104 (quoting Spicer v. Williamson, 132 S.E. 291, 293 (N.C. 1926)).

73. *Id.* at 104 (quoting *Gregg*, 428 U.S. at 173 (joint opinion of Stewart, Powell & Stevens, JJ.)).

74. *See id.* at 104–05.

75. *See, e.g.*, Farmer v. Brennan, 511 U.S. 825, 829 (1994) (requiring a showing that the official was subjectively aware of the risk).

76. 501 U.S. 294 (1991).

77. *Id.* at 298 (quoting Rhodes v. Chapman, 452 U.S. 337, 347 (1981)).

point to a "specific deprivation of a single human need," such as food, warmth, or exercise.[78]

Applying *Estelle*, courts have discerned "no . . . distinction between the right to medical care for physical ills and its psychological or psychiatric counterpart."[79] As the Supreme Court stressed in *Brown v. Plata*,[80] adequate medical and mental health treatment are clearly necessities;[81] severe suffering and death could result from deprivation of such treatment just as starvation and death could occur if one were not fed.[82] In *Ruiz v. Johnson*,[83] a federal district court went further, stating, "As the pain and suffering caused by a cat-o'-nine-tails lashing an inmate's back are cruel and unusual punishment by today's standards of humanity and decency, the pain and suffering caused by extreme levels of psychological deprivation are equally, if not more, cruel and unusual."[84]

Prison authorities can be held liable not only for past harms inflicted on inmates but also for exposing inmates to the substantial risk of serious future harm.[85] The failure to treat a medical need that could result in further significant injury or unnecessary or wanton infliction of pain poses such a risk,[86] and, as specifically noted by the U.S. Court of Appeals for the Seventh Circuit in

78. *Id.* at 304–05.

79. Bowring v. Godwin, 551 F.2d 44, 47 (4th Cir. 1977); *see also* Ohlinger v. Watson, 652 F.2d 775, 777 (9th Cir. 1980) ("Appellants have a constitutional right to such individual treatment as will give each of them a realistic opportunity to be cured or to improve his mental condition."); Inmates of Allegheny Cnty. Jail v. Pierce, 612 F.2d 754, 763 (3d Cir. 1979) ("[W]e perceive no reason why psychological or psychiatric care should not be held to the same standard [as care for physical illnesses].").

80. 131 S. Ct. 1910 (2011).

81. *Id.* at 1928.

82. *Id.* The *Plata* Court concluded that in 2006, as a consequence of California prisons' grossly deficient levels of mental illness assessment, treatment, and intervention, California inmates suffered a suicide rate 80% higher than the national average for prison populations. *Id.* at 1924.

83. 37 F. Supp. 2d 855 (S.D. Tex. 1999), *rev'd sub nom.* Ruiz v. United States, 243 F.3d 941 (5th Cir. 2001).

84. *Id.* at 914. The court concluded that the Texas prison system's practice of placing mentally ill inmates into segregated isolation units constituted cruel and unusual punishment. *Id.* at 915; *see also* Madrid v. Gomez, 889 F. Supp. 1146, 1265 (N.D. Cal. 1995) (holding that segregation of inmates already suffering from mental illness into a special Security Housing Unit constituted an Eighth Amendment violation).

85. *See, e.g.*, Farmer v. Brennan, 511 U.S. 825, 845 (1994) (quoting Helling v. McKinney, 509 U.S. 25, 36 (1993)) (describing what proof is needed to obtain "injunctive relief to prevent a substantial risk of serious injury from ripening into actual harm"); *Helling*, 509 U.S. at 35 (concluding that deliberate indifference to a prisoner's exposure to chemicals "that pose an unreasonable risk of serious damage to [the prisoner's] future health" is actionable under the Eighth Amendment); Shakka v. Smith, 71 F.3d 162, 168 (4th Cir. 1995) ("[T]he Eighth Amendment provides protection against conditions that have not resulted in past injury, but are reasonably likely to cause serious harm in the future.").

86. *See* Clement v. Gomez, 298 F.3d 898, 904 (9th Cir. 2002)

Wellman v. Faulkner,[87] deficiencies in a prison mental health system expose inmates with serious mental illness to a substantial risk of serious future harm.[88]

The Eighth Amendment liability inquiry also contains a subjective component: in order to prove a constitutional violation the claimant must show prison officials acted with "'deliberate indifference' to inmate health or safety."[89] The evidence must demonstrate that a prison official "knows of and disregards an excessive risk to inmate health or safety; the official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference."[90]

C. *The Prison Litigation Reform Act and the Plaintiff-Inmates' Choice to Litigate in South Carolina State Court*

Under Section 1983 of the Civil Rights Act of 1871, a prisoner may seek redress in federal court when a person acting under color of law deprives the prisoner of rights guaranteed by the Constitution or federal laws.[91] However, the *T.R.* plaintiffs chose to seek relief in South Carolina state court, relying on article I, section 15 of the state constitution.[92] The terms of the South Carolina provision have been interpreted to require the same analysis as that to be performed in an Eighth Amendment case.[93] By suing in state court, the *T.R.* plaintiffs "avoid[ed] the onerous and uncertain requirements" of the Prison Litigation Reform Act (PLRA).[94] Enacted in 1996, the PLRA ostensibly sought

87. 715 F.2d 269 (7th Cir. 1983).

88. *Id.* at 272; *see also Helling*, 509 U.S. at 35 (affirming a lower court's holding that deliberate indifference to a prisoner's exposure to second-hand cigarette smoke could be an Eighth Amendment violation); Flynn v. Doyle, 672 F. Supp. 2d 858, 876 (E.D. Wis. 2009) (recognizing a cause of action for systemic deficiencies that put inmates' health at risk); *Madrid*, 889 F. Supp. at 1256 (concluding that prison officials were deliberately indifferent to the potential harm to inmates' mental health caused by "systemic deficiencies" in the prison's mental health care system); *cf.* Neiberger v. Hawkins, 208 F.R.D. 301, 317 (D. Colo. 2002) (allowing class certification in a suit against a state mental health facility where there was evidence of "systemic problems in the institution which appear to violate the law").

89. *Farmer*, 511 U.S. at 834 (citing Wilson v. Seiter, 501 U.S. 294, 302–03 (1991)).

90. *Id.* at 837.

91. 42 U.S.C. § 1983 (2012). *See generally* Matthew P. Previn, Project, *Procedural Means of Enforcement Under 42 U.S.C. 1983*, 83 GEO. L.J. 1498 (1995) (describing the procedure for seeking relief under 42 U.S.C. § 1983).

92. "All persons shall be, before conviction, bailable by sufficient sureties, but bail may be denied to persons charged with capital offenses or offenses punishable by life imprisonment, or with violent offenses defined by the General Assembly, giving due weight to the evidence and to the nature and circumstances of the event. Excessive bail shall not be required, nor shall excessive fines be imposed, *nor shall cruel, nor corporal, nor unusual punishment be inflicted*, nor shall witnesses be unreasonably detained." S.C. CONST. art. I, § 15 (emphasis added).

93. *See* State v. Wilson, 306 S.C. 498, 512, 413 S.E.2d 19, 27 (1992).

94. E-mail from Daniel J. Westbrook, Counsel for Plaintiffs, *T.R. v. S.C. Dep't of Corr.*, to author (Oct. 16, 2014, 4:14 PM) (on file with author).

"to promote administrative redress, filter out groundless claims, and foster better prepared litigation of claims aired in court."[95]

Critics of the PLRA, however, argue that the statute's procedural requirements "keep[] countless serious claims from reaching the courts—including claims of physical and sexual abuse, indifference to inmate on inmate rape, gross mistreatment of confined juveniles, and *markedly deficient medical and mental health treatment*."[96] PLRA critics focus on several provisions as unduly limiting a prisoner's ability to seek relief in federal court: the requirement that prisoners exhaust all administrative avenues before proceeding to federal court, limitations on monetary damages for mental and emotional injuries, the burden of filing fees and filing requirements on indigent and pro se claimants, and limits on the number of complaints that can be filed by prisoners with previously dismissed claims.[97]

In the context of this litigation, the greatest potential impediment to swift access to relief in federal court was the PLRA's administrative exhaustion requirement, which mandates that "[n]o action shall be brought with respect to prison conditions under section 1983 of this title, or any other [f]ederal law, by a prisoner confined in any jail, prison, or other correctional facility until such administrative remedies as are available are exhausted."[98] This exhaustion requirement "applies to all inmate suits about prison life, whether they involve general circumstances or particular episodes, and whether they allege excessive force or some other wrong."[99] Moreover, as affirmed by the Supreme Court in *Woodford v. Ngo*,[100] inmates must show "proper exhaustion" of all administrative resources,[101] meaning that a prisoner must comply with all time limits, appeal levels, and other procedural requirements of the administrative remedy process.[102]

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95. Porter v. Nussle, 534 U.S. 516, 528 (2002).

96. SAVE: COAL. TO STOP ABUSE & VIOLENCE EVERYWHERE, REFORM THE PRISON LITIGATION REFORM ACT (PLRA) 1 (2009) (emphasis added), *available at* http://www.savecoalition.org/pdfs/save_final_report.pdf.

97. *See* SAVE: COAL. TO STOP ABUSE & VIOLENCE EVERYWHERE, *supra* note 96, at 1–5 (citations omitted) (suggesting changes to the PLRA); Tasha Hill, *Inmates' Need for Federally Funded Lawyers: How the Prison Litigation Reform Act,* Casey*, and* Iqbal *Combine with Implicit Bias to Eviscerate Inmate Civil Rights*, 62 UCLA L. REV. 176, 198–209 (2015) (citations omitted) (discussing problems with the PLRA).

98. 42 U.S.C. § 1997e(a) (2012).

99. *Porter*, 534 U.S. at 532.

100. 548 U.S. 81 (2006).

101. *Id.* at 90 (quoting Pozo v. McCaughtry, 286 F.3d 1022, 1024 (7th Cir. 2002)). *But see Developments in the Law—The Law of Mental Illness*, 121 HARV. L. REV. 1114, 1145–55 (2008) (citations omitted) (arguing that the PLRA should be read in harmony with the Americans with Disabilities Act to characterize mentally ill inmates as incapable of bringing a grievance and therefore potentially excused from the exhaustion requirement).

102. *Woodford*, 548 U.S. at 90–91; *see also* Ivy A. Finkenstadt, *Representing Prisoner Clients: Prison Litigation Reform Act*, MD. B.J., Nov.–Dec. 2011, at 58, 61 (citing *Woodford*, 548 U.S. at 90–91).

The PLRA's exhaustion requirement threatens to take a toll on potentially credible complaints. Facing such an administrative obstacle course, inmates are less likely to be successful or to litigate at all.[103] Prisoners such as the plaintiffs in *T.R.* may, however, choose to pursue an action in state court.

III. THE COURT'S ASSESSMENT OF SCDC'S MENTAL HEALTH PROGRAM: APPLYING THE CONSTITUTIONAL STANDARD

A. SCDC Exposed Inmates to a Substantial Risk of Harm

To evaluate whether SCDC's mental health program subjected mentally ill inmates to a substantial risk of harm, Judge Baxley used the framework developed in *Ruiz v. Estelle.*[104] A constitutionally adequate prison mental health program must have six essential elements: (1) a systematic program for screening and evaluating inmates to identify those in need of mental health care; (2) a treatment program that involves more than segregation and close supervision of mentally ill inmates; (3) employment of a sufficient number of trained mental health professionals; (4) maintenance of accurate, complete, and confidential mental health treatment records; (5) administration of psychotropic medication only with appropriate supervision and periodic evaluation; and (6) a basic program to identify, treat, and supervise inmates at risk for suicide.[105] The judge's findings under each prong of the *Ruiz v. Estelle* protocol are presented below.

1. A Systematic Program for Screening and Evaluating Inmates to Identify Those in Need of Medical Care

SCDC's program for screening and evaluating inmates failed to identify and classify those in need of mental care, thereby exposing them to a substantial risk of serious harm.[106] As of 2011, SCDC had diagnosed only 12%–13% of the inmate population with a mental illness and placed them on SCDC's mental health caseload.[107] At trial, SCDC's own expert, Dr. Scott Haas, testified that seriously mentally ill inmates normally comprise approximately 18% of the prison population, and plaintiffs' expert testified that a conservative estimate of

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103. *See* HUMAN RIGHTS WATCH, NO EQUAL JUSTICE: THE PRISON LITIGATION REFORM ACT IN THE UNITED STATES 3 (2009), *available at* https://www.hrw.org/reports/2009/06/15/no-equal-justice (noting that there is strong evidence that "the PLRA has simply tilted the playing field against prisoners across the board"). Indeed, "[b]y 2006 the number of prisoner lawsuits filed per thousand prisoners had fallen 60[%] since 1995." *Id.*

104. 503 F. Supp. 1265, 1339 (S.D. Tex. 1980), *aff'd in part, rev'd in part*, 679 F.2d 1115 (5th Cir. 1982), *amended in part, vacated in part*, 688 F.2d 266 (5th Cir. 1982) (per curiam).

105. *Id.*

106. T.R. v. S.C. Dep't. of Corr., No.: 2005-CP-40-2925, slip op. at 8–9 (S.C. Ct. Com. Pl. Jan. 8, 2014).

107. *Id.* at 8.

SCDC's seriously mentally ill population would be approximately 17%.[108] The court, relying on the 17% estimate, concluded that the lower number of diagnosed inmates indicated deficiencies in the SCDC screening and evaluation process that created a high probability that hundreds of inmates had been overlooked and were not receiving appropriate treatment.[109] SCDC's inaccurate screening also led it to misjudge both the number of mental health professionals and the cost of appropriate treatment.[110]

SCDC also regularly and persistently failed to follow its own mental health screening protocols requiring that an inmate meet with a mental health counselor within forty-eight hours of being assigned to that counselor's caseload[111] and that inmates whom a counselor identified as needing psychiatric treatment were to meet with a psychiatrist within thirty days of the counselor's assessment.[112] By placing inmates with serious mental illness into the general prison population prior to evaluation and treatment, SCDC exposed these inmates to a substantial risk of harm and endangered other inmates and prison personnel.[113]

2. *A Treatment Program that Involves More than Segregation and Close Supervision of Mentally Ill Inmates*

a. *SCDC's Overreliance on Segregation*

SCDC's treatment program relied heavily on segregation as opposed to treatment.[114] This overuse of segregation defied relevant professional standards for disciplinary detention.[115] After noting the American Correctional Association (ACA) recommendation that isolation of inmates from the general population should be used only for short periods of time,[116] the court stressed the ACA's warnings about how segregation adversely affects the mental health of inmates. "Inmates whose movements are restricted in segregation units may develop symptoms of acute anxiety or other mental health problems; regular psychological assessment is necessary to ensure the mental health of any inmate confined in such a unit beyond [thirty] days."[117]

SCDC's own Mental Health Regional Coordinator acknowledged the increased risk factors for psychosis and suicide for inmates confined in a Special

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108. *Id.* Additional evidence introduced at trial suggested that an accurate range of inmates with a serious mental condition would be approximately 15%–20%. *See id.*

109. *Id.*

110. *Id.* at 8–9.

111. *Id.* at 9.

112. *Id.*

113. *Id.*

114. *Id.* at 10.

115. *See id.* at 13.

116. *Id.* (quoting AM. CORR. ASS'N, STANDARDS FOR ADULT CORRECTIONAL INSTITUTIONS 175 (3d ed. 1990)).

117. *Id.* (quoting AM. CORR. ASS'N, *supra* note 116, at 81).

Management Unit (SMU).[118] However, mentally ill SCDC inmates were twice as likely as other inmates to be placed in a SMU and three times as likely to be placed in solitary confinement—often for non-assaultive behavior.[119] Mentally ill inmates also served longer periods in SMUs than non-mentally ill inmates.[120] The "cold and inordinately filthy" conditions of the SMU cells also, in the court's words, fell "below what is acceptable for a [twenty-first] century correctional institution."[121]

However, the court was most alarmed by the significantly delayed delivery of psychiatric treatment in the SMU.[122] While there, mentally ill inmates received no group therapy, their sessions with psychiatrists and counselors were often held in a nonconfidential setting, and, as inmate medical records showed, patients could not see mental health professionals on a timely basis.[123]

b. SCDC's Pattern of Inappropriate and Excessive Use of Force

SCDC's use of force to manage the conduct of mentally ill inmates was disproportionate, unnecessary, and excessive.[124] During the period of January 2008 to September 2011, SCDC officers subjected 27% of the plaintiff class of mentally ill inmates to the use of force compared to only 11% of other inmates.[125] Of the top thirty inmates most frequently subjected to the use of force, twenty-six were on the mental health caseload; several of these inmates had mental conditions serious enough to require multiple hospitalizations.[126] The court determined that SCDC's overreliance on the use of force stemmed, in part, from insufficient training of correctional officers in how to deal with mentally ill inmates.[127]

Plaintiffs' corrections expert, Steve J. Martin, testified that SCDC showed a pattern of unnecessary force in multiple cases where there was no harm, threat of

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118. *Id.* at 14.

119. *Id.* at 10–11. Inmates in segregation stay confined to their cells for 23–24 hours per day and have limited privileges including visitation, telephone, and canteen. *Id.* at 10.

120. *Id.* at 11. As of January 13, 2012, the average cumulative disciplinary detention sentence for mentally ill inmates was 657 days, compared to 383 days for non-mentally ill inmates. *Id.* Mentally ill inmates' sentences in segregation also greatly exceeded their projected release dates by, on average, 1968 days, compared to 1,065 days for non-diagnosed inmates. *Id.*

121. *Id.* at 15.

122. *See id.* at 14.

123. *Id.* In one extreme example, a mentally ill inmate who was required to see a counselor every thirty days and a psychiatrist every ninety days, had on several occasions gone up to nine months without seeing a counselor and up to 120 days without seeing a psychiatrist. *Id.*

124. *Id.* at 16.

125. *Id.*

126. *Id.* at 17.

127. *Id.* Notably, SCDC training coordinator Yolanda Delgado testified in her deposition "that 'less than a handful' of correctional officers attended training sessions intended to improve the staff's knowledge and skills in dealing with mentally ill inmates." *Id.*

harm, or exigent circumstances.[128] For example, Martin reviewed over one thousand SCDC incident reports involving the use of Oleoresin Capsicum pepper spray (OC spray) and found that SCDC's practices violated national standards and SCDC's own use of force policies.[129] In some cases, OC spray was used as a form of punishment rather than to address a threat of harm or other exigent circumstances.[130] Corrections officers routinely used spray in greater amounts and at closer distances than specified by manufacturers' instructions, and in extreme instances, SCDC officers used MK-9 crowd control fogger devices in individual closed cells.[131] Martin, who has reviewed thousands of uses of OC spray in American prisons and jails, testified that "he had 'never seen MK-9, a crowd control contaminant, so frequently used by a correctional force inappropriately.'"[132]

SCDC's use of physical restraints on mentally ill inmates was also unnecessary and excessive.[133] Contrary to SCDC's own policy and accepted national standards, officers placed mentally ill inmates in restraint chairs for predetermined, four-hour increments.[134] These inmates were placed naked in the chairs, often in a painful, "crucifix" position.[135] The inmates were given infrequent bathroom breaks, forcing many to urinate on the chair.[136] Officers restrained one mentally ill inmate for twelve hours after he did not receive adequate psychotropic medication, and restrained two inmates for nearly four hours while they were bleeding from self-inflicted wounds and in serious need of medical attention.[137]

A significant cause of this pattern of inappropriate use of force was SCDC's failure to provide effective supervisory oversight.[138] SCDC contended that the examples presented at trial were isolated incidents of inappropriate conduct by individual correctional officers.[139] However, in his review of more than one thousand cases, plaintiffs' expert Martin found very few cases referred to senior management, and virtually no findings of excessive or unnecessary force.[140] The court agreed with Martin's assessment, in which he characterized the nearly complete absence of findings of inappropriate force in a system of more than 23,000 inmates as a "huge red flag."[141] The court concluded that SCDC's

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128. *Id.*
129. *Id.*
130. *Id.*
131. *Id.* at 18.
132. *Id.*
133. *Id.*
134. *Id.* However, Judge Baxley remarked that this practice was changed shortly before the beginning of the trial. *Id.* at 18 n.9.
135. *See id.* at 18–20.
136. *Id.* at 19.
137. *Id.* at 18–19.
138. *See id.* at 20.
139. *Id.*
140. *Id.*
141. *Id.* at 20–21.

pattern and practice of using unnecessary and excessive use of force went unreported, uninvestigated, and unmanaged.[142]

c. SCDC Psychiatrists Had Little Involvement in Inmates' Treatment

SCDC psychiatrists had limited involvement in creating and administering treatment plans for mentally ill inmates, a deficiency which the court found to be a substantial contributing factor to the ineffectiveness of SCDC's treatment program.[143] Deposition testimony by SCDC psychiatrists exposed a lack of knowledge about several facets of the treatment program including policies and procedures, levels of care, referral criteria for different levels of care, and the role of mental health counselors in the treatment process.[144] The court found that SCDC psychiatrists, the lead mental health professionals in the system, lacked intimate knowledge of the processes and procedures of the system they were expected to direct, and were therefore unable to provide effective services.[145]

d. SCDC Limited Inmates' Access to Higher Levels of Care

The current SCDC treatment program failed to provide mentally ill inmates with sufficient access to higher levels of care.[146] SCDC's treatment system is made up of four tiers of care, listed from lowest to highest levels of services and staffing: "outpatient, area, intermediate (ICS), and inpatient."[147] Over the period examined at trial, there was a sharp decline in the caseload for the SCDC treatment programs that called for the highest amount of services and staffing.[148] SCDC provided "no persuasive explanation for the decline in the number of inmates receiving higher levels of services during a period when the overall inmate population and mental health case[load] remained flat."[149] The court found this limited access to higher levels of care posed a substantial risk of harm for inmates afflicted with serious mental illness.[150]

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142. *Id.* at 21.
143. *Id.*
144. *Id.*
145. *Id.*
146. *Id.* at 22.
147. *Id.*
148. *See id.* at 22–23. From 2008 to 2012, the combined ICS and Area Mental Health caseload at SCDC decreased by 40%. *Id.* at 22. Between 2008 and 2011, Lee and Lieber Correctional Institutions went from having an equal number of inmates receiving area and outpatient treatment to having almost six times as many inmates receiving outpatient treatment as area treatment. *See id.* At Gilliam Psychiatric Hospital, part of Kirkland Correctional Institution, the eighty-eight bed inpatient facility operated at full capacity in the 1990s, while at the time of trial only forty-seven beds were filled. *Id.* at 22–23.
149. *Id.* at 23.
150. *Id.*

3. Employment of a Sufficient Number of Trained Mental Health Professionals

SCDC's mental health program was substantially understaffed, which greatly inhibited its ability to provide effective services to its mentally ill inmates.[151] At the time of trial, SCDC's psychiatric staff, personnel such as psychiatrists and psychiatric nurse practitioners, consisted of 5.5 full-time equivalents (FTEs): a ratio of 1:437 to serve the estimated 2,409 inmates on psychotropic medication.[152] The court noted, however, that if the percentage of SCDC's mentally ill inmates were 17% instead of the 12.9% diagnosed by SCDC, then the ratio was closer to 1:575 to serve the population of 3,170.[153] The court found that an appropriate ratio for inmates on psychotropic medication would be 1 psychiatric staff member to 150–200 inmates needing care.[154]

SCDC was also understaffed in clinical psychologists and counselors.[155] From 2007 to 2011, SCDC averaged only 0.3 FTE psychologists to serve a population of 23,000 inmates, a ratio of 1:69,697.[156] SCDC's expert, Dr. Scott Hass, testified that his former employer, the Kentucky Department of Corrections, had 15 to 16 FTE psychologists to serve a population of 12,000 to 13,000 inmates, a ratio of 1:800.[157] The expert witnesses called by both the plaintiffs and SCDC agreed that a more appropriate ratio for counselors at these facilities is 1:40.[158]

Regrettably, many counselors employed by SCDC were unqualified.[159] A 2009 internal SCDC audit at the Lee, Lieber, and Perry Area Mental Health Institutions revealed that 55% of the mental health counselors were rated "unsatisfactory" or "satisfactory, but with major concerns."[160] The audits noted instances of mentally ill inmates going months without speaking to a counselor or psychiatrist, treatment plans that were out of date and incomplete, poor documentation of medication administration and group therapy sessions, and repeated audit failures by counselors.[161]

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151. *Id.*
152. *Id.*
153. *Id.*
154. *Id.* at 23–24. The court reached this conclusion based on the plaintiffs' expert testimony. *See id.* at 23.
155. *Id.* at 24.
156. *Id.*
157. *Id.*
158. *Id.*
159. *Id.* at 25.
160. *Id.*
161. *Id.*

4. Maintenance of Accurate, Complete, and Confidential Health Treatment Records

Reviewing SCDC's treatment plans, the court noted that "[i]n order to be effective, treatment plans must be accurate, complete, readily accessible to professional staff, and confidential."[162] SCDC's documentation and maintenance of their records were poor, and the plans and automated medical records (AMRs) "d[id] not clearly state problems, objectives, goals, or even identify plan-responsible staff."[163] SCDC's outdated computer system was unable to pull up even the most basic information, including the number and names of inmates assigned to different mental health programs, the number of inmates who had made suicide attempts, or the number of inmates whose psychotropic medications had expired without being renewed.[164] The court, finding that SCDC's recordkeeping system was "outmoded, poorly maintained, and not readily accessible to all staff," found "that SCDC's failure to maintain accurate and complete mental health treatment records" put mentally ill inmates at a substantial risk of serious harm.[165]

5. Administration of Psychotropic Medication Only with Appropriate Supervision and Periodic Evaluation

SCDC mental health staff members rely on mentally ill inmates' Medication Administration Records (MARs) for crucial treatment information.[166] At trial, plaintiffs introduced MARs showing no staff signatures and no record that medications had been administered.[167] At best, SCDC staff failed to accurately maintain the records, and at worst the staff failed to provide needed medication, omissions with potentially tragic consequences, as the death of inmate Robert Hamberg reveals.[168] SCDC records showed that Hamberg's morning antipsychotic medication had expired, meaning he was only receiving his evening medication, or half of his prescribed dosage of antipsychotic medication.[169] However, Hamberg's counselor recorded that he was receiving the appropriate dosage of medication.[170] On June 9, 2010, Hamberg committed suicide at Perry Correctional Institution (Perry).[171]

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162. *Id.* at 26.
163. *Id.*
164. *Id.*
165. *Id.*
166. *Id.* at 27.
167. *Id.*
168. *Id.* at 27–28.
169. *Id.* at 27–28.
170. *Id.* at 27–28.
171. *Id.* at 28.

At many institutions, SCDC used pill lines, formed between 3:00 and 4:00 a.m., to distribute medication.[172] Mentally ill inmates were required to wake themselves in time to stand in line and then administer their own medications, a significant and potentially overwhelming responsibility for those already struggling with compliance due to their illness and medication side effects.[173] The court found that SCDC's "failure to appropriately supervise, evaluate, and dispense psychotropic medications" created a substantial risk of harm for inmates suffering from serious mental illness.[174]

6. A Basic Program to Identify, Treat, and Supervise Inmates at Risk for Suicide

a. SCDC's Appalling Conditions in Crisis Intervention Cells

At trial, plaintiffs introduced evidence that between 2008 and 2011, seven mentally ill SCDC inmates died in CI cells—six by suicide—deaths that were both foreseeable and preventable.[175] The CI cells were part of segregation units in which the inmates were denied access to needed medical treatment and oversight of their condition.[176] While in CI cells, inmates rarely saw psychiatrists, did not participate in group therapy, and were only monitored by mental health staff Monday through Friday, excluding holidays.[177]

Stripped of blankets and mattresses, CI cells were also cold and filthy; while there, inmates were forced to sleep naked on steel or concrete floors.[178] From 2008 to 2010, officers at the Lieber Correctional Institution (Lieber), as well as other SCDC facilities, placed mentally ill inmates in "alternative" CI cells: holding cells, recreation cages, interview booths, or even shower stalls.[179] Over half of such alternative placements were for twelve hours or longer with several stays exceeding twenty-four hours.[180] Denied bathroom breaks, inmates were often forced to eat and sleep in the same place they urinated or defecated, conditions the court described as "dehumanizing."[181]

172. *Id.*
173. *Id.*
174. *Id.*
175. *Id.* at 28 & n.11.
176. *Id.* at 28–29.
177. *Id.* at 29. Evidence showed this already relaxed protocol was often violated. *Id.*
178. *Id.*
179. *Id.*
180. *Id.*
181. *Id.* at 30.

b. SCDC's Failure to Provide Constant Supervision

SCDC policy did not mandate continuous observation of inmates in CI cells, even if the inmate was on suicide watch.[182] SCDC policy only required staff to check inmates confined in CI cells at fifteen-minute intervals, with such checks to be documented in cell-check logs.[183] The information in the logs was often inaccurate or even falsified.[184] Consequently, the court found SCDC's suicide prevention practices and crisis intervention procedures created a substantial risk of harm to seriously mentally ill inmates.[185]

B. SCDC's Deliberate Indifference to Inmates' Harm

The court presented an exhaustive list of incidents proving that SCDC had been aware of the risk of harm to seriously mentally ill inmates for over a decade, a period preceding the filing of the *T.R.* lawsuit and continuing throughout the litigation.[186] In 2000, Dr. Raymond Patterson, who had been hired by SCDC to inspect its mental health program, described the program as being in a state of "profound crisis."[187] Later that same year, "a Joint Legislative Proviso Committee report concluded that 'inmates with mental illness [were] not receiving adequate treatment . . . and oftentimes le[ft] prisons worse off than when they entered.'"[188] Three years later, a task force that included three former SCDC directors determined that Gilliam Psychiatric Hospital was "clearly inadequate."[189] That same year, a South Carolina Department of Mental Health report on SCDC's mental health program, as quoted by the court, stated that "[t]he lack of psychiatric coverage has resulted in a critical situation, with extremes of poor care, inhumane treatment, and dangerousness."[190] The court also quoted SCDC's own Director Jon Ozmint as writing in 2003 that "[t]he current plight of persons with mental illness at SCDC is at a crisis level."[191]

In June 2005, the plaintiffs filed their complaint, alleging multiple constitutional deficiencies in SCDC's mental health program.[192] Over the next four years, plaintiffs' experts issued eight inspection reports criticizing

182. *Id.*
183. *Id.*
184. *See id.*
185. *Id.* at 31.
186. *Id.* at 32.
187. *Id.*
188. *Id.* (quoting S.C. DEP'T OF MENTAL HEALTH & S.C. DEP'T OF CORR., JOINT LEGISLATIVE PROVISO COMMITTEE REPORT ON MENTAL HEALTH CARE FOR PRISON INMATES IN SOUTH CAROLINA 2 (2000), *available at* http://www.scribd.com/doc/197808880/Exh-B).
189. *Id.*
190. *Id.* (alteration in original).
191. *Id.* (alteration in original).
192. *Id.*

conditions at and noting deficiencies in SCDC's facilities.[193] In 2007, SCDC psychiatrist Dr. Michael Kirby wrote to his supervisor expressing serious concerns about SCDC's mental health program.[194] The next year, SCDC investigator Lloyd Greer issued a report on his investigation of Jerome Laudman's death at Lee Supermax.[195] From 2008 to 2010, Lieber SMU logs recorded the use of shower stalls and other inappropriate CI alternative placements.[196] From 2009 to 2010, SCDC was aware that the shortage of counselors at Perry created severe deficiencies in mental health services.[197] Finally, a 2010 U.S. Department of Justice report criticized SCDC's medication management and administration practices[198] and, in 2012, internal SCDC data found that patient-to-counselor ratios were too high.[199]

Despite the abundant evidence that SCDC was aware of its program deficiencies even before discovery and trial in the *T.R.* litigation, as the court stressed, "from 1999 until the filing of this action in 2005, SCDC did virtually nothing to address, much less eliminate, the substantial risks of serious harm to which class members were exposed."[200] During the trial, SCDC pointed to measures undertaken since the beginning of the litigation to improve its mental health program: hiring two administrators and administrative staff, reorganizing its group therapy program, increasing its psychiatric staff FTEs, formulating a new protocol for addressing self-injurious behavior, creating mental health dorms, increasing the use of tele-psychiatry, holding new training programs for clinical and security staff, and conducting more counselor audits.[201] However, the court concluded that "'[t]o rely on intervening events occurring after suit has been filed the defendants must satisfy the heavy burden of establishing that these such events "have completely and irrevocably eradicated the effects of the alleged violations."'"[202]

SCDC's "half-hearted" measures did not meet that heavy burden.[203] As the court observed, "'[p]atently ineffective gestures purportedly directed towards remedying objectively unconstitutional conditions do not prove a lack of deliberate indifference, they demonstrate it.'"[204] Rather than "accept[ing] the obvious . . . and com[ing] forward in a meaningful way to try and improve its mental health system," SCDC spent hundreds of thousands of taxpayer dollars

193. *Id.* at 32–33.
194. *Id.* at 33.
195. *Id.*
196. *Id.*
197. *Id.*
198. *Id.* In fact, "SCDC's own counselor audits" uncovered these "unsatisfactory practices and major deficiencies." *Id.*
199. *Id.*
200. *Id.*
201. *Id.* at 33–34.
202. *Id.* at 34 (quoting Thomas v. Bryant, 614 F.3d 1288, 1320–21 (11th Cir. 2010)).
203. *Id.* at 34–35.
204. *Id.* at 35 (quoting Coleman v. Wilson, 912 F. Supp. 1282, 1319) (E.D. Cal. 1995)).

defending the State through a series of predictably unsuccessful motions and discovery requests, ultimately delaying inmate relief for nearly nine years.[205]

IV. THE LIMITS OF SOUTH CAROLINA'S REMEDIAL STRATEGY

A. The Parties' Preliminary Agreement

On January 15, 2015, the plaintiffs and SCDC announced that they had agreed on the terms of a multi-year plan to remedy the constitutional violations identified by Judge Baxley.[206] The plan contemplates the hiring of additional mental health professionals and staff, construction projects to upgrade SCDC facilities, and the development and implementation of new SCDC policies.[207] The plan anticipates a three-year budget increase, subject to state legislative approval.[208] More than $8 million would be dedicated to the hiring of additional staff to screen inmates for mental illness, the administration of medication, and the delivery of suicide prevention services.[209] An additional $1.6 million would fund facility improvements, including the expansion of recreation yards, the installation of new surveillance equipment to monitor inmate safety, the modification of cells to replace breakable glass with non-breakable material, and the addition of food flaps to cell doors.[210] Recently, Governor Nikki Haley, in her executive budget for the 2015–2016 fiscal year, sought over $4 million in recurring funds to improve care for mentally ill inmates.[211]

The successful implementation of the improvement plan would be a step forward for the state of South Carolina, and a victory for incarcerated inmates suffering from mental illness. However, the changes outlined in the plan do not address the overrepresentation of the mentally ill among the incarcerated or the phenomenon driving the correctional system to assume the role of mental health care provider with its attendant costs and administrative challenges. To set the

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205. *Id.* at 44–45. At the end of his opinion, Judge Baxley wrote that "[t]he court can never criticize any party for a vigorous exercise of offense or defense in civil litigation, for such is the foundation of our adversarial system of justice. But justice in this case is not really about who wins or loses this lawsuit. The hundreds of thousands of tax dollars spent defending this lawsuit, at trial and most likely now on appeal, would be better expended to improve mental health services delivery at SCDC." *Id.* at 45.

206. *See* Kinnard, *supra* note 22; Roldan, *supra* note 22.

207. *Term Sheet*, PROTECTION & ADVOC. FOR PEOPLE WITH DISABILITIES 1–2 (Jan. 12, 2015), http://pandasc.org/wp-content/uploads/2015/01/SCDC-terms-with-all-signatures.pdf.

208. *See id.* at 2; *see also* Kinnard, *supra* note 22 (noting SCDC's plan to seek millions of dollars in additional funding over the next three years).

209. *See Term Sheet*, *supra* note 207, at Exhibit A.

210. *See id.*; *see also* Kinnard, *supra* note 22 (describing facility improvement projects proposed by SCDC officials).

211. *Gov. Nikki Haley Announces Executive Budget FY 2015–16*, S.C. OFF. GOVERNOR (Jan. 12, 2015), http://www.governor.sc.gov/News/Pages/January2015Archive.aspx; Kinnard, *supra* note 22.

course for a humane and sustainable future, policy initiatives must take aim at the overuse of prisons and jails as treatment facilities for the mentally ill.

B. Widening the Reform Horizon

South Carolina is hardly alone in its failure to provide adequate care to mentally ill inmates. The news headlines are replete with accounts of the not so unusual failure of jails and prisons to provide adequate care to mentally ill inmates.[212] Even when state corrections systems make strides toward internal reform, such efforts may be difficult to sustain, as Mississippi's recent experience illustrates.[213] Responding to overwhelming violence and litigation that revealed deplorable conditions, Mississippi sought guidance from the National Institute of Corrections and other states.[214] Focusing on efforts to improve the identification of mental illness among inmates and to limit the use of force, Mississippi's internal institutional changes produced a significant drop in violent incidents and a reduction in population in isolation units.[215] However, a recently filed complaint alleging deplorable and unsafe conditions at East Mississippi Correctional Facility, where 70% of the inmates suffer from serious mental illness,[216] suggests that Mississippi's institutions have not yet achieved full constitutional compliance.[217]

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212. *See, e.g.*, Sascha Cordner, *Mental Health Advocates Suing DOC: "Prison System Must Go Beyond Current Reforms,"* WFSU (Sept. 10, 2014), http://news.wfsu.org/post/mental-health-advocates-suing-doc-prison-system-must-go-beyond-current-reforms (discussing mental health advocates' decision to bring a lawsuit on behalf of mentally ill prisoners in Florida after one mentally ill inmate died of unnatural causes at the Dade Correctional Institution); Parsons v. Ryan, ACLU (Oct. 14, 2014), https://www.aclu.org/prisoners-rights/parsons-v-ryan (describing a settlement agreement between the Arizona Department of Corrections (ADC) and the ACLU in which the ADC agreed to improve mentally ill prisoners' treatment and access to health care); Frederick Reese, *Louisiana Prisoners Sue State for Failing to Provide Mental Health Care*, MINTPRESS NEWS (Aug. 26, 2014), http://www.mintpressnews.com/louisiana-prisoners-sue-state-failing-provide-mental-health-care/195850/ (describing a lawsuit filed by mentally ill prisoners in Louisiana who, "despite being found not guilty by reason of insanity," were "denied access to psychiatric care").

213. *See infra* notes 214–17 and accompanying text. *See generally* Glenn Smith & Cynthia Roldan, *New Asylums: Mentally Ill, in Prison and Locked Away Alone*, POST & COURIER (Apr. 13, 2014), http://www.postandcourier.com/article/20140413/PC16/140419799 (noting that Mississippi is "considered a leader in th[e] movement" to reform prison segregation policies).

214. *See* John Buntin, *Mississippi's Correction Reform: How America's Reddest State—and Most Notorious Prison—Became a Model of Corrections Reform*, GOVERNING (Aug. 2010), http://www.governing.com/topics/public-justice-safety/courts-corrections/mississippi-correction-reform.html.

215. *See id.*

216. Jerry Mitchell, *East Mississippi Prison Called "Barbaric,"* CLARION-LEDGER (Sept. 25, 2014, 9:35 PM), http://www.clarionledger.com/story/news/2014/09/25/east-mississippi-prison-called-barbaric/16242399/.

217. Margaret Winter of the ACLU's National Prison Project described the facility as "in chaos, with conditions so dangerous—violence, filth, callous denial of prisoners' serious medical

Sheriff Tom Dart of Cook County, Illinois, has stressed the inherent limits of reform strategies that are confined to making changes within correctional institutions.[218] According to 2005 data, out of 64,735 inmates in Illinois jails and state prisons, an estimated 10,358 were seriously mentally ill.[219] Data also shows that the number of inmates identified as seriously mentally ill in the Cook County Jail alone—over 2,600—was significantly higher than the total number of patients—1,860—in the state's five remaining psychiatric hospitals.[220] To Sheriff Dart, these statistics document a tragic reality: "'It's criminalizing mental illness.'"[221]

Since taking charge in Cook County, Dart has created some of the most innovative programs in the country to address the needs of mentally ill inmates, efforts that extend beyond hiring doctors, psychologists, and training staff.[222] Most notably, Dart has created an after-care program that offers follow-up care to departing inmates, including a twenty-four-hour help line and help in obtaining medication.[223] Still, to Dart, his efforts do not represent the best solution: "'I can't conceive of anything more ridiculously stupid by government than to do what we're doing right now,' Dart says."[224] Dart points out that the current system incurs excessive costs in treating mentally ill inmates in jail.[225] Importantly, inmates keep coming back into the system when they run out of medication.[226] According to Dart, taxpayers then pay to stabilize inmates who, without treatment on the outside, will often be rearrested for infractions related to their underlying mental disorders.[227] To end this cruel and wasteful cycle, communities must acknowledge the too frequent criminalization of mental illness[228] and commit to making better access to mental health treatment a public

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and mental health needs—that the only meaningful remedy is an injunction to protect all prisoners." *Id.*

218. *See* Kristof, *supra* note 65.

219. E. FULLER TORREY ET AL., TREATMENT ADVOCACY CTR. & NAT'L SHERIFFS' ASS'N, MORE MENTALLY ILL PERSONS ARE IN JAILS AND PRISONS THAN HOSPITALS: A SURVEY OF THE STATES tbl.1 (2010), *available at* http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf.

220. TORREY ET AL., *supra* note 23, at 46.

221. Kristof, *supra* note 65.

222. Laura Sullivan, *Mentally Ill Are Often Locked Up in Jails That Can't Help*, NPR (Jan. 20, 2014, 4:50 PM), http://www.npr.org/2014/01/20/263461940/mentally-ill-inmates-often-locked-up-in-jails-that-cant-help.

223. Phil Kadner. *The Cost of Saving on Mental Health Care*, SOUTHTOWNSTAR (Chi.), Oct. 15, 2014, *available at* http://www.suffredin.org/news/newsitem.asp?newsitemid=7133.

224. Sullivan, *supra* note 222.

225. *See* Kristof, *supra* note 65.

226. *See id.*

227. *See id.*

228. *See generally* Anastasia Cooper, Note, *The Ongoing Correctional Chaos in Criminalizing Mental Illness: The Realignment's Effects on California Jails*, 24 HASTINGS WOMEN'S L.J. 339 (2013) (examining the relationship between the mentally ill and California's prisons and jails); Georgia Lee Sims, Note, *The Criminalization of Mental Illness: How Theoretical Failures Create*

health priority.[229]

V. NEW YORK CITY'S NEW DIRECTION

New York City's Rikers Island Jail, which houses over 12,000 inmates, is the state of New York's largest de facto mental institution.[230] Riker's Island has recently come under fire for its mistreatment of prisoners, especially those classified with serious mental illness.[231] Violence, both aimed at and perpetrated by correctional officers, had become commonplace in the facility's daily reports,[232] and the overuse of segregation and use of excessive force to handle inmates generated scores of complaints and lawsuits.[233] In December 2014, the U.S. Department of Justice (DOJ) revealed its plan to sue the city "over widespread civil rights violations in the handling of adolescent inmates at Rikers Island."[234] DOJ's decision to sue stemmed in part from its scathing August 2014 report which recounted "a pervasive and 'deep-seated culture of violence' directed at teenage inmates at Rikers."[235] At the time, the DOJ was awaiting the decision of a federal judge in Manhattan regarding whether it would be allowed to join an existing class action suit, *Nunez v. City of New York*,[236] which focuses not just on the treatment of adolescents, but on inmates of all ages at Rikers Island.[237]

In response to ongoing problems, New York City has begun to make substantial changes in its jail operations, giving correctional officers more

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Real Problems in the Criminal Justice System, 62 VAND. L. REV. 1053 (2009) (describing the failures of the criminal justice system in addressing mental illness).

229. *See, e.g.*, Dean Aufderheide, *Mental Illness in America's Jails and Prisons: Toward a Public Safety/Public Health Model*, HEALTH AFF. BLOG (Apr. 1, 2014), http://healthaffairs.org/blog/2014/04/01/mental-illness-in-americas-jails-and-prisons-toward-a-public-safetypublic-health-model/ ("[W]e need a paradigm shift that conceptualizes mental illness in jail and prison environments as a public safety/public health issue.").

230. TORREY ET AL., *supra* note 23, at 72 (estimating that one-third of male inmates and two-thirds of female inmates at Rikers Island were mentally ill).

231. *See* Michael Schwirtz, *Rikers Island Struggles with a Rise in Violence*, N.Y. TIMES, Mar. 19, 2014, at A1.

232. *See id.*

233. *See id.*

234. Benjamin Weiser et al., *U.S. Plans Suit over Conditions at Rikers Island*, N.Y. TIMES, Dec. 19, 2014, at A1.

235. *Id.*

236. *See* United States' Motion to Intervene Pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997, Nunez v. City of New York, No. 11 Civ. 5845(LTS)(JCF) (S.D.N.Y. Dec. 18, 2014). The *Nunez* litigation began in 2011 when Mark Nunez brought a complaint against the New York City Department of Correction for abuses he allegedly sustained while an inmate at Rikers Island in 2010. *See* Complaint, Nunez v. N.Y.C. Dep't of Corr., No. 11 Civ. 5845 (S.D.N.Y. Aug. 18, 2011). The court subsequently granted the government's request to join the case. *See* Order Granting as Unopposed Motion to Intervene by the United States, Nunez v. City of New York, No. 11 Civ. 5845(LTS)(JCF) (S.D.N.Y. Dec. 23, 2014).

237. Weiser et al., *supra* note 234.

training on how to deal with mentally ill inmates, adding video surveillance to document officers' use of force, and appointing a new administrator.[238] These changes are, however, only part of a more ambitious reform agenda that could become a template for correctional systems across the country.

A. New York City's Action Plan and Its Virtues

In June 2014, Mayor Bill de Blasio announced an initiative to coordinate the city's criminal justice and behavioral healthcare systems to ensure more efficient use of criminal justice resources and more effective deployment of treatment services.[239] Developed by a task force that consulted with more than 400 leaders and participants[240] over a 100-day period, the *Action Plan* seeks to ensure that, when appropriate, people with mental health disorders will be diverted from the criminal justice system and that current jail inmates with behavioral health needs will be connected to appropriate care, both during their incarceration and after their release.[241]

The most important aspect of the New York City program is its recognition of "the interdependent and intersecting nature of the behavioral health and criminal justice systems."[242] The plan addresses not only the systems' recognized five major points of contact,[243] "but also the overlap between them."[244] The focus of the task force's recommendations is on making sure that individuals with behavioral health needs:

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238. *Id.*; *see also* Michael M. Grynbaum, *De Blasio Cites Drop in Crime Since Taking Office*, N.Y. TIMES, Mar. 12, 2014, at A24 (describing the newly-appointed head of the city's Department of Correction as someone who "has focused on reducing the use of solitary confinement and violence in prisons").

239. MAYOR'S TASK FORCE ON BEHAVIORAL HEALTH & THE CRIMINAL JUSTICE SYS., CITY OF N.Y., ACTION PLAN 6 (2014), *available at* http://www1.nyc.gov/assets/criminal justice/downloads/pdf/annual-report-complete.pdf. A study conducted by the New York City Department of Health and Mental Hygiene showed that about 400 people make up the population that most frequently returns to the city's jails. *Id.* Those 400 people have been admitted to jail at least eighteen times over the past five years and have an even greater rate of mental illness and substance abuse problems than the general prison population, with 67% having a mental health need, 21% having a serious mental illness, and 99.4% reporting a substance abuse disorder. *Id.* During the five-year period studied, the group accounted for 10,000 jail admissions and 300,000 days in jail. *Id.* Because 85% of the charges against the group were misdemeanors or violations, the report raises a serious question as to whether incarceration is the proper response. *Id.*

240. The task force and its executive committee included "commissioners from [c]ity and [s]tate agencies, experts from the private sector, representatives from law enforcement and behavioral health agencies, district attorneys, defenders, judges and other court representatives, academics[,] and service providers." *Id.*

241. *Id.*

242. *Id.*

243. *Id.* at 6–7 (providing the five major points of contact: "On the Street," "From Arrest to Disposition," "In Jail," "Release and Re-entry," and "Back in the Community").

244. *Id.* at 6.

> do not enter the criminal justice system in the first place; if they do enter, that they are treated outside of a jail setting; if they are in jail, that they receive treatment that is therapeutic rather than punitive in approach; and that, upon release, they are connected to effective services.[245]

The cornerstone of the plan is the coordination of policy across city and state agencies.[246] At each intervention point officials will work together to ensure the strategies are implemented in a timely and effective manner, to determine if the steps being taken are cost effective, and to assess how best to replicate, sustain, and integrate successful strategies into the normal procedures of the city.[247]

B. Interactions with Law Enforcement on the Street

The report recognizes that law enforcement officers are often the first to come into contact with people with behavioral health issues,[248] and appropriately, they need to be trained in the best practices for de-escalating crises and assessing possible alternatives to jail or hospitalization.[249]

This "crisis intervention training" (CIT) model of first responder training originated in a 1988 partnership among the Memphis, Tennessee Police Department, the Memphis Chapter of the Alliance for the Mentally Ill (NAMI), and two local universities.[250] The partnership "was established for the purpose of developing a more intelligent, understandable, and safe approach to mental crisis events."[251] Its success has prompted many local police departments to adopt this training and response protocol.[252]

The task force concluded that in the future such training should be integrated into the police academy curriculum, but, in the interim, training of over 5,500 of

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245. *Id.* at 7.

246. *See id.* at 8.

247. *Id.*

248. *See id.*

249. *Id.*; *cf.* Sheehan v. City & Cnty. of San Francisco, 743 F.3d 1211, 1232 (9th Cir.) (holding that Title II of the Americans with Disabilities Act applies to arrests and suits can be brought under Title II when the police arrest an individual after mistaking the effects of a disability as criminal conduct or when officers fail to make reasonable accommodations for a disability when investigating or arresting a suspect), *cert. granted*, 135 S. Ct. 702 (2014).

250. *Crisis Intervention Team*, CITY OF MEMPHIS, http://www.memphistn.gov/Government/PoliceServices/CrisisInterventionTeam.aspx (last visited Apr. 12, 2015).

251. *Id.*

252. *See, e.g.*, Sarah Rosario, *9 Investigates: Law Enforcement Trains for Situations Involving Mentally Ill*, WSOCTV (May 19, 2014, 5:03 PM), http://www.wsoctv.com/news/news/special-reports/law-enforcement-trains-situations-involving-mental/nfzX5/ (discussing the Charlotte-Mecklenburg Police Department's use of CIT); Gisela Telis, *Training Prepares Police to Respond in Mental Health Crises*, ARIZ. PUB. MEDIA, https://originals.azpm.org/p/azill-featured/2014/3/4/30822-training-prepares-police-to-respond-in-mental-health-crises/ (last updated Mar. 5, 2014) (describing CIT in Pima County, Arizona).

the city's officers should begin immediately.[253] To aid these officers, the *Action Plan* calls for community-based diversion "drop-off" centers that will serve as an immediate alternative to jail to provide short-term assessment, linkage to care, and short-term crisis assistance.[254] Based on pre-booking diversion programs used in other jurisdictions, these drop-off centers will provide "[twenty-four]-hour respite care, case management, and supervised withdrawal detox services followed by referrals to on-going substance [abuse] treatment as appropriate."[255]

C. Mental Health Screening from Arrest to Disposition

More than 355,000 people are arraigned each year in New York City courts, with around 80,000 placed in jail.[256] To reduce the incarceration of mentally ill individuals, the *Action Plan* calls for the implementation of expanded supervised release programs guided by a scientifically validated risk assessment tool.[257] By restricting pretrial detention to those who are a substantial flight risk or who cannot safely be managed by community programs, arrestees will be given greater access to mental health and substance abuse services delivered through face-to-face or telephone contact.[258]

Furthermore, the *Action Plan* calls for universal screening of arrestees for physical and mental health problems.[259] A pilot program will aim to ensure that, before arraignment, every person arrested is screened for physical, mental, and substance abuse treatment needs.[260] This will facilitate possible diversion to other services, outside of jail, except when safety concerns preclude this approach.[261] The *Action Plan* also recommends the use of a specialized

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253. MAYOR'S TASK FORCE ON BEHAVIORAL HEALTH & THE CRIMINAL JUSTICE SYS., *supra* note 239, at 8.

254. *Id.* at 9.

255. *Id.*

256. *Id.*

257. *Id.* at 9–10. Currently, the New York City Criminal Justice Agency provides validated flight risk assessments based on this model to inform release decisions. *Id.* at 10. This same process will be utilized to analyze risk factors associated with the supervised release of mentally ill individuals. *See id.*

258. *Id.* at 10.

259. *Id.*

260. *Id.*

261. *Id.* While diversion programs take many forms, the purpose is the same: to "divert individuals with serious mental illness (and often co-occurring substance use disorders) away from jail and provide linkages to community-based treatment and support services." Substance Abuse & Mental Health Servs. Admin., *What Is Jail Diversion?*, SAMHSA'S GAINS CENTER FOR BEHAV. HEALTH & JUST. TRANSFORMATION, http://gainscenter.samhsa.gov/topical_resources/jail.asp (last visited Apr. 12, 2015). *See generally* Kasey Mahoney, Note, *Addressing Criminalization of the Mentally Ill: The Importance of Jail Diversion and Stigma Reduction*, 17 MICH. ST. U. J. MED. & L. 327 (2013) (recommending diversion programs as a solution to the problems caused by deinstitutionalization).

One type of diversion program, mental health courts, "are courts that specialize in handling mentally ill offenders and whose function is to direct and supervise their treatment in the

approach for veterans, efforts to decrease reliance on monetary bail, and development of a strategy to shorten case processing times.[262]

D. Improvements in Jail Procedures and Treatment

The task force set as its central objective the reduction of violence and the enhancement of staff and inmate safety.[263] To that end, the *Action Plan* focuses on evidence-based staffing and programming strategies to de-escalate jail conflicts and address problematic inmate behavior.[264] To decrease violence, newly-trained crisis intervention teams made up of both New York City Department of Correction (DOC) and health services personnel will use the same de-escalation tactics and symptom identification procedures their law enforcement counterparts will employ on the streets.[265]

The *Action Plan* also calls for reducing the use of punitive segregation by implementing alternative sanctions and limiting the use of segregation to swift, targeted responses to serious offenses.[266] This provision reflects a rapidly emerging consensus that confinement in segregation units constitutes cruel and unusual punishment for inmates who are already mentally ill and for those at unreasonably high risk of suffering serious mental illness as a result of such conditions of confinement.[267] As stated by Sandra Schank, a staff psychiatrist at

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community as opposed to [with] jail or prison sentences." *Id.* at 338 (citing Shane Levesque, *Closing the Door: Mental Illness, the Criminal Justice System, and the Need for a Uniform Mental Health Policy*, 34 NOVA L. REV. 711, 727 (2010)). *See generally* Caitlin T. Harrington, Note, *Breaking the Cycle and Stepping Out of the "Revolving Door": Why the Pre-Adjudication Model Is the Way Forward for Illinois Mental Health Courts*, 2013 U. ILL. L. REV. 319 (discussing various approaches taken by mental health courts and recommending a model in which charges against mentally ill defendants are put on hold pending the defendant's completion of treatment). South Carolina currently operates mental health courts in Greenville, Columbia, and Charleston, and some lawmakers have suggested expanding the program. Tim Smith, *S.C. Lawmakers Look to Expand Mental Health Courts*, WLTX 19 (Mar. 11, 2014, 8:15 AM), http://www.wltx.com/story/news/2014/03/11/sc-lawmakers-look-to-expand-mental-health-courts/6283873/.

262. MAYOR'S TASK FORCE ON BEHAVIORAL HEALTH & THE CRIMINAL JUSTICE SYS., *supra* note 239, at 10–11.

263. *Id.* at 11.

264. *See id.* at 11–12.

265. *Id.* at 11.

266. *Id.* at 11–12.

267. *See, e.g.*, Madrid v. Gomez, 889 F. Supp. 1146, 1267 (N.D. Cal. 1995) (concluding that prolonged solitary confinement of the mentally ill and those "at an unreasonably high risk of suffering serious mental illness as result of" such confinement constitutes an Eighth Amendment violation). *See generally* Elizabeth Alexander & Patricia Streeter, *Isolated Confinement in Michigan: Mapping the Circles of Hell*, 18 MICH. J. RACE & L. 251 (2013) (citations omitted) (discussing the use of solitary confinement and its effects on the mentally ill); Thomas L. Hafemeister & Jeff George, *The Ninth Circle of Hell: An Eighth Amendment Analysis of Imposing Prolonged Supermax Solitary Confinement on Inmates with a Mental Illness*, 90 DENV. U. L. REV. 1, 36 (2012) (describing the "broad range of adverse psychological symptoms" associated with long-term isolation in prisons); Laura Matter, Note, *Hey, I Think We're Unconstitutionally Alone Now: The Eighth Amendment Protects Social Interaction as a Basic Human Need*, 14 J. GENDER

a California prison, "'It's a standard psychiatric concept, if you put people in isolation, they will go insane. . . . Most people in isolation will fall apart.'"[268] For inmates suffering from serious mental illness, this effect is exacerbated: "For [mentally ill] inmates, placing them in [solitary confinement] is the mental equivalent of putting an asthmatic in a place with little air to breathe."[269]

New York City has now discontinued the use of solitary confinement for prisoners with serious mental illness.[270] Before this change, approximately four hundred mentally ill inmates per day were assigned to solitary confinement, serving an average of 53.5 days under twenty-three-hours-per-day lockdown.[271] Seriously mentally ill inmates are now sent to the Clinical Alternative to Punitive Segregation (CAPS) unit, which more closely resembles an inpatient psychiatric hospital unit than a jail cell.[272] While there, inmates receive group and individual therapy and are monitored by staff members trained to handle mentally ill individuals.[273] Less seriously mentally ill inmates are assigned to the Restrictive Housing Unit (RHU).[274] Here, solitary confinement may still be used, but inmates can participate in an incentive-based behavioral program until they can be reintroduced into the general population.[275]

The New York City DOC also plans to employ evidence-based staffing and programming strategies.[276] By providing all uniformed correctional officers with additional training in how to manage people with mental health issues, and implementing strengthened standards for use of force, violence is expected to abate.[277] Programming will include specialized services for adolescents, expansion of substance use disorder treatment programs, and expansion of

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RACE & JUST. 265 (2010) (citations omitted) (arguing that overuse of solitary confinement violates the Eighth Amendment by depriving prisoners of social interaction).

268. HUMAN RIGHTS WATCH, ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS 149 (2003) (quoting Interview by Human Rights Watch with Sandra Schank, Staff Psychiatrist, Mule Creek State Prison, Cal. (July 19, 2002)), *available at* http://www.hrw.org/reports/2003/usa1003/usa1003.pdf.

269. *Madrid*, 889 F. Supp. at 1265.

270. Sean Gardiner, *Solitary Jailing Curbed*, WALL ST. J. (Jan. 5, 2014, 9:56 PM), http://online.wsj.com/articles/SB10001424052702304617404579302840425910088.

271. *Id.*

272. *Id.*; *see also Clinical Alternatives to Incarceration/Restrictive Housing Unit (RHU)*, CITY OF N.Y. DEP'T CORRECTION, http://www.nyc.gov/html/doc/html/press/caps-rhu.shtml (last visited Apr. 13, 2015) (describing the CAPS unit).

273. Gardiner, *supra* note 270; *see also Clinical Alternatives to Incarceration/Restrictive Housing Unit (RHU)*, *supra* note 272 ("[T]here are several clinical staff on the units at all times during the day and evening tours engaging the inmates in individual and group therapy and supervised activities.").

274. Gardiner, *supra* note 270.

275. *Id.*

276. *See* MAYOR'S TASK FORCE ON BEHAVIORAL HEALTH & THE CRIMINAL JUSTICE SYS., *supra* note 239, at 12.

277. *See id.*

programming aimed at idle time and violence reduction through vocational skill-building, educational programming, and discharge planning services.[278]

E. Planning for Release and Reentry

Perhaps most important in preventing recidivism and re-incarceration is proper release planning.[279] Even if inmates receive appropriate treatment while incarcerated, without continuity of treatment and follow-up within the community, there is great risk of psychological deterioration and recurrence of behaviors that may lead to re-incarceration.[280] Release and reentry plans, usually developed with inmates' input, prepare inmates to look for housing, apply for financial aid, and seek further counseling and medication; they also provide inmates with a plan to deal with mental health emergencies, and set expectations for reintegration into society.[281]

In order to improve current discharge services, the *Action Plan* establishes a Medicaid implementation team to minimize disruption in public health insurance coverage.[282] Additional provisions call for the expansion of in-jail teams to connect people to programs such as Health Homes,[283] and enhanced coordination among various state and city agencies including the State's Council on Community Re-Entry and Reintegration.[284]

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278. *Id.*

279. *See generally* Doug Jones, Note, *Discharge Planning for Mentally Ill Inmates in New York City Jails: A Critical Evaluation of the Settlement Agreement of* Brad H. v. City of New York, 27 PACE L. REV. 305, 307 (2007) ("Empirical studies show that discharge planning reduces recidivism.").

280. *See* Am. Ass'n of Cmty. Psychiatrists, *AACP Position Statement on Post-Release Planning*, AACP, http://www.communitypsychiatry.org/pages.aspx?PageName=AACP_Position_Statement_on_Post_Release_Planning (last visited Apr. 13, 2015).

281. *See id.*

282. MAYOR'S TASK FORCE ON BEHAVIORAL HEALTH & THE CRIMINAL JUSTICE SYS., *supra* note 239, at 13. Beginning in 2014, Medicaid will cover treatment for individuals being released from incarceration and suffering from mental illness and substance abuse in states that opt to expand Medicaid eligibility, a decision which South Carolina has not made at this point. SUSAN D. PHILLIPS, THE SENTENCING PROJECT, THE AFFORDABLE CARE ACT: IMPLICATIONS FOR PUBLIC SAFETY AND CORRECTIONS POPULATIONS 3 (2012) (citing Patricia Blair & Robert B. Greifinger, *The Health Care Reform Law: What Does it Mean for Jails?*, CORRECTCARE, Winter 2011, at 10), *available at* http://sentencingproject.org/doc/publications/inc_Affordable_Care_Act.pdf; *Where the States Stand on Medicaid Expansion*, ADVISORY BOARD COMPANY (Feb. 11, 2015, 11:47 AM), http://www.advisory.com/daily-briefing/resources/primers/medicaidmap.

283. "A Health Home is a [Medicaid] care management service model whereby all of an individual's caregivers communicate with one another so that all of a patient's needs are addressed in a comprehensive manner." *Medicaid Health Homes*, N.Y. ST. DEP'T HEALTH, https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/ (last visited Apr. 13, 2015). This is accomplished "through a 'care manager' who oversees and provides access to all of the services an individual needs to assure that the [individual] receive[s] everything necessary to stay healthy, out of the emergency room[,] and out of the hospital." *Id.*

284. MAYOR'S TASK FORCE ON BEHAVIORAL HEALTH & THE CRIMINAL JUSTICE SYS., *supra* note 239, at 13–14; *see also* David Howard King, *New State Re-entry Council Takes Aim at*

F. Integration Back into the Community

Finally, once inmates are released back into the community, the city plans to "expand[] access to supportive housing, employment, education, and other appropriate services."[285] The New York Supreme Court for New York County addressed the gravity of this issue in 2000 when it granted an injunction requiring mental health discharge planning, characterizing the injury faced by discharged inmates as "decompensation for many former inmates, and a return to the cycle of likely harm to themselves and[] others, through substance abuse, mental and physical health deterioration, homelessness, indigence, crime, rearrest, and re[-]incarceration."[286] The *Action Plan* addresses this problem by expanding access to supportive housing, providing paths to employment and self-sufficiency, and adding behavioral health teams to the city's probation department.[287]

VI. CONCLUSION: AN OPPORTUNITY FOR FURTHER REFORM

The parties' preliminary agreement in *T.R.* signifies a victory for the plaintiffs and other similarly affected mentally ill inmates within SCDC. With any luck, the South Carolina General Assembly will pass the budgetary requests and the new minimally adequate provisions will be put into effect, ensuring no further harm comes to the state's mentally ill prisoners. However, this litigation should be just one chapter in a larger story as South Carolina acknowledges both a treatment crisis for mentally ill inmates and the over-incarceration of the mentally ill. Using a reform strategy like New York City's, South Carolina could make meaningful progress toward enlisting its criminal justice and correctional systems into a broader public health response to the treatment needs of the mentally ill.

Recidivism, GOTHAM GAZETTE (Aug. 6, 2014), http://www.gothamgazette.com/index.php/government/5200-new-reentry-council-takes-aim-recidivism-cuomo-prison (discussing the newly created state council and its "dual goal[s] of aiding [prisoners] in setting out on a productive, healthy path and easing the burden on taxpayers [caused] by recidivism").

285. MAYOR'S TASK FORCE ON BEHAVIORAL HEALTH & THE CRIMINAL JUSTICE SYS., *supra* note 239, at 14.

286. *Brad H. v. City of New York*, 712 N.Y.S.2d 336, 345 (Sup. Ct. 2000).

287. MAYOR'S TASK FORCE ON BEHAVIORAL HEALTH & THE CRIMINAL JUSTICE SYS., *supra* note 239, at 14–15.